STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE WEST	55 N MISSION DR INDIANAPOLIS, IN 46214

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R000000	This visit was for a State Residential Licensure Survey. Survey dates: May 6 & 7, 2013 Facility number: 011840 Provider number: 011840 AIM number: N/A Survey team: Lora Brettnacher, RN-TC Heather Lay, RN Census bed type: Residential: 61 Total: 61 Census by payor source: Other: 61 Total: 61 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on May 8, 2013 by Randy Fry RN.	R000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R000033	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to ensure a posting of state agencies included a toll free number for filing a complaint of resident abuse, neglect, misappropriation of resident property, and other practices with the Indiana State Department of Health (ISDH). This deficient practice affected 61 of 61 residents residing in the facility. Findings include: On 5/7/13 at 9:45 A.M., tour of the facility was initiated with the	R000033	I. Upon discovery, the facility posted the toll free number for filing a complaint of resident abuse, neglect, misappropriation of resident property and other practices. II. As all residents could be affected, the facility has taken the following corrective actions. III. The toll free number was posted and residents will be informed per group meeting of the whereabouts/availability of the toll free number and instruction for filing a complaint with the Indiana State Department of Health. IV. As a means of quality	05/16/2013

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	Maintenance Supervisor. At that time, a posting of state agencies, addresses, and phone numbers was observed in the main entrance of the facility. The posting did not indicate how to contact ISDH or provide the toll free complaint hotline number. On 5/7/13 at 10:00 A.M., in an interview, the Administrator indicated there were no postings with the complaint hotline toll free number or how to file a complaint with the ISDH.		assurance, the Administrator shall conduct review of postings during weekly rounds, in an effort to confirm that all required numbers/information remains posted for resident access.	

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R000150	410 IAC 16.2-5-1.5(g) Sanitation & Safety Standards -Noncompliance (g) Each facility shall have a policy concerning pets. Based on interview and record review, the facility failed to follow their policy regarding pet vaccinations for 1 of 3 pets housed in the facility. During an interview on 5/6/2013 at 11:00 A.M., the Executive Director (ED) indicated, the facility had three residents who owned pets. The ED was asked to provide documentation of the pets current vaccination records. During an interview on 5/7/2013 at 10:50 A.M., the ED indicated, he was unable to provide documentation of current vaccinations for a resident's cat. A document titled, "Rabies Vaccination Certificate" indicated, this cat had a rabies, feline panleukopenia, feline rhinotracheitis, and feline calicivrus vaccination on 3/23/2009, and those vaccinations expired on 3/23/2010. The ED was unable to provide documentation this cat had received it's required current vaccinations. The facility's current pet policy dated May 22, 2006, was reviewed on 5/7/2013 at 10:45 A.M. The policy	R000150	I. Upon discovery, the resident secured an appointment for vaccinations to be obtained. II. It was confirmed that all other pets housed within the facility were current with required vaccinations. III. In an effort to ensure ongoing compliance, the vaccination schedules were placed on a calendar. The Administrator or designee will monitor to remind residents of need for annual vaccinations in an effort to remain compliant with maintaining documentation of current vaccinations for pets residing in the facility. Any newly added pets shall be added to the vaccination schedules accordingly. IV. As a means of quality assurance, the Administrator will maintain records of said vaccinations and verify with the resident annual vaccinations are obtained once reminded, and obtain records of the same.	05/16/2013

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	indicated, ". . .Any pet housed in the facility shall have periodic veterinary examinations and required immunizations in accordance with state and local health regulations. . . ."			

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R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure complete and accurate clinical records were maintained regarding medication administration [Resident #1] and laboratory testing [Resident #6]. This deficient practice affected 2 of 7 residents reviewed for physician orders for medications and laboratory testing. Findings include: 1. On 5/6/13 at 11:15 A.M., Resident #1's record was reviewed. Diagnoses included, but were not limited to, hypertension, depression, dementia, anxiety, and renal failure. Resident #1 received hemodialysis three times per week. A "Physician's Order" dated 7/27/12, included, but was not limited to, "Hold all AM [morning] medications on dialysis days... Administer upon	R000349	I. Regarding Resident #1, employees who documented administration at 9 a.m., when, in fact the medication had been administered upon return from dialysis (as ordered), were re-educated as to correct documentation of medication administration times. Regarding Resident #6, the physician was notified of the omitted PT/INR and further physician orders will be followed accordingly. II. As all residents could be affected, the orders for all residents will be reviewed to ensure any specific directives regarding timing of medication administration are being followed and documented accordingly. All physician orders received within the past 30 days have again been reviewed to ensure compliance therewith. III. As a means to ensure ongoing compliance, licensed staff will receive inservice training addressing following physician orders as well as correct documentation of medication	05/16/2013

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	return..." A "Medication Record" dated 3/1/13 through 3/31/13, included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 3/1/13 through 3/31/13. A "Medication Record" dated 4/1/13 through 4/30/13, included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given on 4/1, 4/2, 4/3, and 4/4]. There was no documentation that the above morning medications were held on dialysis days [Tuesday, Thursday, and Saturday]. On 5/7/13 at 10:15 A.M., the Director of Nursing [DoN] indicated Resident		administration. IV. As a means of quality assurance, the DON or designee will review all newly received orders on scheduled days of work and will verify compliance with correct transcription and execution of ordered labs/diagnostics, as well as review medication administration records for compliance with correct documentation of administration should the medication be ordered at times other than routine medication administration times. Should non-compliance be noted, staff shall be addressed and re-educated.	

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	#1 was given all her morning medications upon return from dialysis. He indicated she returned from dialysis between 11:00 A.M. to 1:00 P.M.. In addition, the DoN indicated since Resident #1 did not return from dialysis within an acceptable timeframe for administration of the scheduled 9:00 A.M. medications, the actual time the morning medications were given should be documented on the medication administration record. He indicated nursing staff failed to accurately document the administration time of morning medications on dialysis days. 2. On 5/6/13 at 11:40 A.M., Resident #6's record was reviewed. Diagnoses included, but were not limited to, heart valve replacement, progressive dementia, and depression. Resident #6 was discharged from the facility on 4/15/13 for rehabilitation. A physician's orders, dated 3/13/13, included, but was not limited to, "PT/INR [laboratory testing for Coumadin [anti-coagulant medication] levels]..." There was no documentation in Resident #6's clinical record of the results for the laboratory test.			

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	On 5/7/13 at 10:00 A.M., the Director of Nursing indicated the facility failed to complete the PT/INR that was ordered on 3/13/13.			

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R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident's annual tuberculin skin test was completed per the Indiana State Department of Health guidelines. This deficient practice affected 1 of 7 residents reviewed for tuberculosis screening [Resident #4]. Findings include: On 5/6/13 at 10:55 A.M., Resident #4's record was reviewed. Diagnoses included, but were not limited to, major depression, dysphagia, and	R000410	I. Resident #4 received annual mantoux testing upon observance of the oversight. II. The medical records of all residents were reviewed to confirm timely annual testing had been conducted and recorded. III. As a means to ensure ongoing compliance, the DON or designee shall maintain an ongoing monthly calendar of annual mantoux testing and verify the completion of said testing on a monthly basis. IV. As a means of quality assurance, the DON or designee shall report to the Administrator on a monthly basis those	05/16/2013

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	alcohol dependency. A Mantoux [tuberculin skin test] record included, but was not limited to, "Mantoux Tests: Date given: 3/6/12... Date read: 3/8/12... Results: 0 millimeters..." There was no documentation in Resident #4's clinical record regarding a tuberculin skin test for March, 2013. On 5/7/13 at 9:30 A.M., the Director of Nursing indicated the facility failed to administer Resident #4's yearly tuberculin skin test. He indicated Resident #4 was administered the tuberculin skin test on 5/6/13.		residents due annual mantoux testing and completion thereof.	